

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



: Aetna Choice® POS II - TRS-Care Standard (Non-Medicare Eligible Retirees and/or Dependents in a Network Area)

TEXAS PUBLIC SCHOOL EMPLOYEE GROUP INS. PROGRAM
Coverage Period: 01/01/2020-12/31/2020

Coverage for: Eligible Employee (EE) Only; EE+ Family
Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.trscarestandardaetna.com or call 1-800-367-3636. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-367-3636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : EE Only \$1,500; EE+ Family \$3,000. Out-of- <u>Network</u> : EE Only \$3,000; EE+ Family \$6,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.trscarestandardaetna.com .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : EE Only \$5,650; EE+ Family: Individual \$5,650/ Family \$11,300. Out-of- <u>Network</u> : EE Only \$11,300; EE+ Family: Individual \$11,300/ Family \$22,600.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Under a family <u>plan</u> , each person's individual claims count toward the family out-of-pocket maximum. After a person meets the individual out-of-pocket maximum, their expenses will be covered at 100%.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care services not covered under this <u>plan</u> & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Visit www.trscarestandardaetna.com or call 1-800-367-3636 for a list of in- <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a TRS Virtual Health medical visit	TRS Virtual Health video/phone consult	\$30 fee per consult, applies to <u>deductible</u> . After <u>deductible</u> , plan pays 80%; you pay 20% <u>coinsurance</u>	NA	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at https://info.caremark.com/t/rscarestandard</p>	Generic drugs	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	Covers 31-day supply (retail), 60-90-day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medications. If you utilize a non-participating pharmacy or a network pharmacy that will not file an electronic claim, you must file a direct claim with CVS Caremark. You will be responsible for any cost difference between the pharmacy charge and the plan reimbursement.

<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at https://info.caremark.com/trscarestandard</p>	Preferred brand drugs	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	Covers 31-day supply (retail), 32-90 day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medications. Starting Jan. 1, 2020, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the generic coinsurance. This cost difference will not apply to your accumulations (deductible or maximum out of pocket).
<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at https://info.caremark.com/trscarestandard</p>	Non-preferred brand drugs	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	20% <u>coinsurance</u> (retail & mail order or Retail-Plus)	Covers 31-day supply (retail), 32-90-day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medications. Starting Jan. 1, 2020, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the generic coinsurance. This cost difference will not apply to your accumulations (deductible or maximum out of pocket).

<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at https://info.caremark.com/trscarestandard</p>	<u>Specialty drugs</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	All prescriptions must be filled through the Caremark Specialty Pharmacy. Copay Assistance Benefit: Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those products. If you use third-party copayment assistance for any such specialty medication, you will not receive credit toward your maximum out-of-pocket or deductible for any copayment or coinsurance amounts that apply to a manufacturer coupon or rebate.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> for non-emergency use out-of-network.
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None

If you need mental health, behavioral health, or substance abuse services	TRS Virtual Health video consult	Consult fee: \$185 psychiatrist (initial visit) \$95 psychiatrist (ongoing visits) \$85 therapy visits*, Consult fee applies to <u>deductible</u> . After <u>deductible</u> , plan pays 80%; you pay 20% <u>coinsurance</u>	NA	*Therapy visits can be with a psychologist, licensed clinical social worker, counselor or therapist
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant (coverage limited to retiree & spouse)	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant (coverage limited to retiree & spouse)	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant (coverage limited to retiree & spouse)	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/calendar year combined with private-duty nursing.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to treatment of Autism and speech therapy for developmental delay.

If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	365 days/stay. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
If you need help recovering or have other special health needs	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network inpatient care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/3 years up to age 19.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 120 visits/calendar year combined with home health care.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-800-367-3636.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,760

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,580

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-367-3636.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance:

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-367-3636.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-367-3636 በነጻ ይደውሉ
Arabic -	1-800-367-3636 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-367-3636 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-367-3636 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-367-3636 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-367-3636-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-367-3636 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-367-3636 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-367-3636.
Chamorro -	Para ayuda gi fino' (Chamoru), ágang 1-800-367-3636 sin gåstu.
Cherokee -	ᏅᏍᏉᏉ ᏌᏍᏉᏉᏍᏉᏉ ᏍᏉᏉᏍᏉᏉᏍᏉᏉ ᏅᏍᏉᏉ (GWY) ᏅᏍᏉᏉᏍᏉᏉᏍᏉᏉ 1-800-367-3636 ᏅᏍᏉᏉ Ꮜ ᏍᏉᏉᏍᏉᏉ ᏍᏉᏉᏍᏉᏉᏍᏉᏉ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-367-3636，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-800-367-3636.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-367-3636 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-367-3636.
French -	Pour une assistance linguistique en français appeler le 1-800-367-3636 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-367-3636 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-367-3636 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-367-3636 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-367-3636 પર કોલ કરો.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-367-3636 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-367-3636
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-367-3636.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-367-3636 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-367-3636.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-367-3636.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-367-3636. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-367-3636 bila malipo.
Syriac -	ܠܚܥܠܐ ܕܡܕܢܬܐ ܕܠܥܝܠܐ ܕܡܕܢܬܐ ܕܠܥܝܠܐ ܕܡܕܢܬܐ ܕܠܥܝܠܐ ܕܡܕܢܬܐ 1-800-367-3636 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-367-3636 nang walang bayad.
Telugu -	భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-800-367-3636 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-367-3636 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-367-3636 ‘o ‘ikai hā ʻōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-367-3636 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-800-367-3636.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-367-3636.
Urdu -	اگر آپ کو کسی زبان کی مدد کی ضرورت ہے تو 1-800-367-3636 پر بلا کوئی خرچہ بلا کر کال کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-367-3636.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-367-3636 פאר א פאצאל.
Yoruba -	Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-800-367-3636 láí san owó kankan rárá.